# THE SECRETARY OF WAR'S

# MEDICAL ADVISORY COMMITTEE

## Report No. 1

21 November 1946

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There is submitted herewith an interim report on certain phases of the studies now in progress by the Medical Advisory Committee to the Secretary of War. The items discussed demand immediate attention because they are urgent in themselves and because some of the recommendations, if approved, would require translation into legislation to be presented to the Congress when it convenes in January 1947.

The Committee's conception of its task is stated in the correspondence leading to its appointment. In a letter to the Secretary of War, dated 24 June 1946, the present chairman, Dr. E. D. Churchill, and Dr. Hugh J. Morgan, recommended that the War Department "affirm the basic premise that it desires to establish a Medical Department that will measure up to civilian standards in professional care," and that an advisory committee be appointed "to formulate plans for such a Department." The letter of reply from the Secretary of War expressed agreement with this premise and stated that "It is unnecessary to say that it is my sincere desire to maintain the medical standards of the Army at the highest possible professional level."

All the work of the Committee has therefore been pointed to this end. In so acting, it has also been proceeding in accordance with the principles laid down by General Eisenhower in his memorandum of 30 April 1946 entitled "Memorandum for Directors and Chiefs of War Department General and Special Staff Divisions and Bureaus and the Commanding Generals of the Major Commands; Subject: Scientific and Technological Resources as Military Assets," in which he stated:

> "The association of military and civilians in educational institutions and industry will level barriers, engender mutual understanding, and lead to the cultivation of friendships invaluable for future cooperation. The realization of our objectives places upon us, the military, the challenge to make our professional officers the equals in knowledge and training of civilians in similar fields and make our professional environment as inviting as those outside."

The challenge so realistically stated by General Eisenhower cannot be met by anything less than an equally realistic approach to the problems of Army medicine as they exist at this time.

This report is concerned with only a single phase of the survey which the Committee is now making of the various problems comfronting the U. S. Army Medical Department, namely, the procurement of medical officers.

The Committee recognizes that it is making an arbitrary distinction in handling this particular problem as if it were separate and distinct from other important and related issues, such as a reappraisal

of the mission of the Army Medical Department, the potentialities inherent in the more efficient utilization of medical personnel by integration of Federal medical services, and the relation of subsidies to medical education. It believes, however, that the distinction is justified because of the necessity of presenting immediately certain specific findings and recommendations as they relate to the urgent problem of procurement of adequate numbers of physicians to establish and maintain acceptable standards of medical care.

The factual data underlying the analyses and recommendations contained in this report are presented as Appendices, and attention is drawn to them as is necessary.

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The Surgeon General recognized as early as December 1943 that the Medical Corps, once demobilization had begun, would be confronted with a serious problem in procurement. On the expectation that a reasonable number of the 45,000 civilian physicians then in uniform might be interested in a Regular Army career, he several times requested a procurement objective, but this was not approved. The opportunity lost at that time is one cause of the present situation (Appendix 1).

The present total procurement objective of the Regular Army Medical Corps based upon an Army of 500,000 men, 5.5 per 1000 ratio, is 2750 Medical Corps officers. The present strength of the Regular Corps is approximately 1200 including those commissioned from the recent integration. Thus, on the basis of the above procurement objective, there is a shortage of 1550 officers. This figure, when compared with the 141 officers procured from the recent integration, indicates that the Army must secure more than ten times as many officers as were obtained at that time. In making this comparison, however, two facts should be recognized that affect any future integration adversely. The first is that quantitatively the future source is considerably reduced. During the first integration there was a field of approximately 45,000 officers or former officers, many of whom might be expected to be interested, whereas in future integration reliance must be placed on the ASTP group of physicians, the maximum number of whom is 12,000. The second fact is that the future source has been reduced even more seriously in quality, because there are virtually no qualified specialists in the ASTP group of physicians. (Appendix II.)

The Staff plan calls for an estimated Army of 1,070,000 for the next several years, and a later strength of 875,000. This necessitates a procurement objective of 5850 medical officers for the immediate

strength and 4800 for the later strength. On the assumption that the maximum strength of the Regular Army Medical Corps will be 2750, there would develop additional requirements of 3100 and 2050 officers in the two periods, respectively, who would have to be reserve officers on extended active duty.

The failure of physicians to manifest interest in the Reserve Corps and the known objections to interruption of civilian practice combine to throw considerable doubt on the possibility that these additional requirements could be met from this source.

The extent of Medical Department needs must be measured first in specialists and thereafter in the total number of physicians of all categories required. Without specialists medical care of a high quality is impossible. The recent integration, however, produced only 36, and minimum requirements in the Regular Army Medical Corps call for at least 825 specialists.

Of the 5850 Medical Corps officers required for the planned Army of 1,070,000, approximately 30 per cent should be specialists of Grades B and C, according to the personnel planning requirements of the Surgeon General's office. The ratio used in the computation of requirements for specialists may not be entirely satisfactory, but it is employed because it is the only criterion immediately available for the purpose. On this basis, the requirement is for 1760

B and C specialists for the next several years, and for 1440 thereafter. In the Regular Army, out of a total strength of 2750 medical officers, 30 per cent should be specialists, or a total of 825 in the B and C grades. The number of present and prospective B and C specialists (including those in retraining) is now 306. This number includes the 36 secured in the first integration as well as approximately 150 officers now in training to qualify as specialists.

The shortages measured against resources are even more striking when different categories of specialization are reviewed. Thus, for an Army of 500,000 strength, the requirement in such important specialties as general and orthopedic surgery is 260, against a total availability, including those in training, of 76. Comparable figures for neuropsychiatry are 120 and 14; for eye, ear, nose and throat 190 and 26; for cardiology, 33 and 0. For an Army of more than this strength the discrepancies would become even greater because, even if a quota of reserve officers on extended active duty could be obtained, it is highly doubtful that this group would contain more than a few specialists. (Appendix III.)

Substantially all specialists who came from civilian life to the Army during the war will have been separated by January 1947. The immediate need for specialists beyond the small number in the Regular Army can be met only in part by the ASTP graduates who had a brief residency training following their internship and who were commissioned

during the past spring and summer. Their required period of service is two years less two months terminal leave, so that they will be leaving the Army within the next fifteen to eighteen months. Even they, by civilian standards, are only partially trained and cannot be considered qualified specialists; but when they are lost, there are no currently available means for supplying professional care even of present standards for most of the troops. This problem is the most acute and the most immediate which the Medical Department faces.

When the total numerical requirement for medical officers is considered, the situation is seen to be only slightly less serious. There are about 3000 ASTP graduates now serving internships who will be available for active duty in July 1947 and who, assuming that the war emergency is not legally terminated before that date, will serve until 1 May 1949. On the other hand, even without reductions for attrition, there will still be by the spring of 1948 an estimated shortage of 1150 medical officers for an Army of 1,070,000. By the spring of 1949 this shortage will be increased by more than 3000, with no presently available way of meeting it.

The difficulties of meeting this procurement objective must be appraised realistically, in terms of certain factors now operating to prevent it. These are (1) the favorable trend of earnings of physicians in civilian life (Appendix IV); (2) competition from other

Federal agencies, especially the Veterans Administration, which attracts physicians of superior attainments by pay above that offered by the Army and which provides in addition the advantages of initial placement based on professional experience and competence, an assurance of continuity in assignment to professional work, a reasonable degree of permanency in place of residence, and promotion on the basis of merit (Appendix V); and (3) the generally negative attitude of the civilian medical profession toward Army medicine (Appendix VI).

A further difficulty to be reckoned with concerns the potential source of physicians, at least quantitatively, for Army service at the moment, namely, the group of recent ASTP graduates. There are two reasons to suggest that the yield from this source is likely to be exceedingly small. The first is the negative attitude manifested by the great majority of these men toward Army service. The survey just completed by the Information and Education Division of the War Department, and personally facilitated by the Secretary of War, indicates that only one out of 386 ASTP graduates now on active duty contemplates applying for a commission in the Medical Corps (Appendix VI). The second reason is that this source for procurement is not only resistant but is steadily diminishing. Some 2000 ASTP graduates have recently been released from active service and another 2500 will complete their Army duty within the next six months. It becomes evident, therefore, that unless prompt action is taken

to provide incentives for these young physicians to remain in service, either on a military or a civilian status, this potential source of physicians for Army service will have come and gone as did the 45,000 AUS officers that served during the war, and another opportunity will have been completely lost. (Appendix II.)

The shortages that have been described are those based on the assumption that war emergency measures will remain in force. Should the Congress declare the emergency at an end and full responsibility for medical service revert to the Regular Army, the Medical Corps at its present strength could support a total Army strength of 184,000, and this only if the troops were deployed within a limited geographic area.

On the basis of these observations, the Committee has endeavored to attack this critical problem of procurement by specific recommendations. These include increased pay, liberalization of rank, improvements of conditions of service and, most important of all, the establishment of a high standard of professional leadership. The employment of civilian specialists on a full-time and part-time basis is also recommended. The direction taken by these recommendations can be summed up in a single phrase quoted from General Eisenhower:- to "make our professional officers the equals in knowledge and training of civilians in similar fields and make our professional environment as inviting as those outside."

First, it is recommended that the salaries of Medical Corps Officers be increased.

Increase in pay is an essential factor in procurement. It will not in itself solve the problem, but it must be provided for if procurement difficulties are to be overcome.

There are several ways in which financial adjustments can be made. The Committee has reviewed the Staff studies concerning them and finds that the rationale of corrective proposals is almost universally based on the establishment of financial and promotional equity between medical officers and other officers. The recommendation made by the Surgeon General, for instance, for an annual salary adjustment of $1,300 over a period of 30 years for officers of the Medical Corps, is based on the principle of reimbursement for the outlays incurred by the young physician for his education and of compensation for his delayed earnings (Appendix VII). The Committee recognizes the rationale of this proposal and considers the level of financial adjustment minimal. There is, however, a much more cogent reason than equity for salary adjustment. The true need for it is not financial equity within the War Department but competitive pressure exerted by civilian practice and, to a certain extent, by the Veterans Administration. The income of medical officers in the Army must be increased to bring it nearer to the range of the financial

opportunities of civilian practice, which today are superior - and by any reasonable estimate will long remain superior - to the opportunities now offered by the Army (Appendix VIII). The scales of pay must be at least comparable to those established by the Veterans Administration. In the absence of action of this sort, physicians will not serve in the Army.

The Committee therefore concurs in the Surgeon General's recommendation for an upward adjustment in the general level of pay for officers of the Army Medical Corps. It also concurs in the principle underlying his additional recommendation that special incentives be established for men of outstanding ability, such as the 25 per cent increase in pay recommended for medical officers who have been certified by the various specialty boards. The Veterans Administration has such a regulation now in effect, and it has proved distinctly advantageous to its procurement program. In citing this example of a special incentive, however, the Committee would emphasize the fact that certification provides a rigid and well established criterion for determining professional competence. It recommends similar special incentives for other areas of military medicine in which qualifying boards do not exist, but only if comparable criteria to determine similar standards of competence can be set up.

Second, it is recommended that the Professional Consultants Divisions of the Office of The Surgeon General be revitalized.

The preeminent position of medicine in the United States Army during World War II was the direct consequence of bringing into military service a segment of the American medical profession that included a considerable number of distinguished specialists. The Regular Army medical officers were assigned to administrative duties. The real burden of the professional aspect of military medicine was therefore carried by civilian physicians in service, under the direction of civilian specialists who served in the Army in the capacity of Consultants. The high quality of professional achievement in World War II was in large part attributable to this civilian direction and civilian leadership. All of it was lost with demobilization. Except for the limited number of specialists still held in service as an emergency measure, and soon to be separated, the medical resources of the Army now consist only of members of the Regular Army Medical Corps, recent graduates of the ASTP, and 550 volunteers.

The Regular Army officers, most of whom have spent five years in administrative work, are for the most part unfitted to assume professional leadership. The Surgeon General's Office has provided for the professional retraining of some 350 of these officers. As of 15 October 1946, 206 were receiving training and 150 had been assigned

following such training. The program represents progress in the right direction but has suffered from several weaknesses, including a short training period and a lack of competent teachers. Furthermore, so far as personnel resources of the Regular Army are concerned, the end of the program is already in sight.

The current situation can be summed up by the simple statement that the medical service of the Army is deteriorating to a dangerous level. It is believed that The Surgeon General will confirm this statement. Detailed facts fully supporting it can be adduced but are considered not be be necessary here. The deterioration is not only reflected in a decline in the quality of medical care being provided for the American soldier. It also serves as a most serious deterrent to the recruitment of the able physicians who alone can reestablish the professional standing of the Army Medical Department.

It is the considered opinion of this Committee that the immediate raising of the level of professional leadership in the Army will be a far more powerful inducement in the procurement of medical officers than increased emoluments will prove to be, though both are essential. Such an improvement, in addition to contributing to the reestablishment of desirable standards of medical care and serving to attract able men into the Army, will also play an essential role in the projected graduate training program of the Medical Department. Every

good physician places great emphasis on his opportunities for training and professional growth, and unless these opportunities are provided in the Army there will be further difficulty in procuring able men and, as a consequence, a further decline in the standards of professional care. (Appendix VI.)

This Committee considers the provision of competent medical leadership of such overwhelming importance that it is willing to recommend extraordinary measures to procure it. One of these measures is a renaissance of the Professional Consultants Divisions as the vital center of the Office of The Surgeon General, with extension of their technical and personnel responsibilities to overseas commands and with proper authority and adequate personnel to fulfill these responsibilities. In no other way can leadership at the top be restored. Distinguished experts in the principal professional fields, including particularly surgery, medicine, and neuropsychiatry, should be installed in The Surgeon General's Office as Consultants, in the grade of general officers, so that by effort and example they can bring hope and give direction to the great group of young physicians now temporarily in service. Increased financial emoluments may be important, but they can never equal in importance the provision of professional leadership for the Army Medical Department (Appendix VI). There is ample evidence that to maintain high standards of medical practice and to discharge effectively the other missions of the

Medical Department, civilian-trained Consultants at the highest level in The Surgeon General's Office are as essential in peace as they were in war, if not more essential.

Physicians of the experience and distinction required for these positions would not be attracted by the rank of a general officer or by the financial emoluments which go with it. From the financial standpoint they can do much better for themselves in the civilian practice of medicine. Provision must therefore be made for them actually to participate in clinical medicine for their own sakes as well as for the sake of the Army Medical Department, to which they would cease to be useful if they separated themselves from professional thought and practice. To accomplish the objective, it is tentatively proposed that professorships (or their equivalent) in the principal specialties be established at the Walter Reed General Hospital, to be occupied by the Chief Consultant in each specialty, who would also serve as the Chief of Service in his specialty at the same hospital. It is not believed that this (or a similar) plan could be instituted immediately, because of the press of other duties if the Professional Consultants Divisions were reestablished, but it could and should be put into effect within a given period of time thereafter. This Committee has taken a completely realistic point of view regarding the likelihood of securing leaders of the desired caliber in the immediate future. It will continue to explore the

possibilities and to study the inducements that may be necessary to implement the program proposed if it is approved in principle.

Third, it is recommended that the present regulations affecting the rank of medical officers be liberalized.

The current ruling that an officer cannot be integrated into the Regular Army above the grade of Major of itself precludes the acquisition of a single highly competent civilian physician. A considerable number of competent professional men might be interested in a Regular Army career if the initial grade were not determined solely on the basis of age or previous military experience but also took cognizance of professional attainments by permitting integration at ranks above that currently stipulated. It is recognized that preferential action should be recommended only if proper safeguards can be established to prevent abuses in the basic plan for integration, but the Committee believes that the necessary safeguards can be set up with a rebirth of the Professional Consultants Divisions, as outlined above, or by other measures. It therefore recommends that The Surgeon General be authorized to integrate into the Regular Army such numbers of key professional personnel in the grades of Lieutenant Colonel and Colonel as may be necessary to meet the professional requirements of the Corps, with due protection against political pressure, but without harassing conditions.

Current regulations and policies affecting promotions in the Medical Department must also be altered. At the present time promotion is a slow but almost automatic process, based on age and length of service, with ability and merit playing minor roles if any. In civilian life the process is more generally the reverse. Promotion is based on merit. The most striking illustration which could be adduced of civilian versus Army medical policy in this respect is the recent appointment to the Professorship of Medicine at the Johns Hopkins University of a young man who spent most of his Army service in the grade of Captain. Had he continued in the Army, under present regulations it would probably take him twenty years to reach a rank comparable to the position he has now attained in civil medicine on the basis of his ability and merit.

It has already been pointed out that the Veterans Administration offers an initial assignment, salary and promotion on the basis of professional experience and competence and, furthermore, gives reasonable assurance of tenure in a specifically designated post.

The Committee therefore recommends such changes in the regulations as are necessary to make promotion dependent upon professional merit and ability rather than, as at present, upon age and length of service.

Fourth, it is recommended that civilian specialists be employed to serve as Consultants on a full-time and part-time basis.

Even with increased emoluments and with improvement of professional leadership and personnel, it seems unlikely that the War Department can secure an adequate number of properly qualified physicians on a military status alone. This certainly will be the case if the emergency is terminated at an early date. As a counter measure to the professional losses suffered at demobilization, as well as to supplement his present meager military resources, The Surgeon General established a comprehensive plan for the use of civilian Consultants in Army hospitals. A large number of Consultants has already been appointed, and an expanding program is under way designed to utilize their services for both consulting and teaching purposes. The measure represents a real advance, but the program, to date, has been visualized as an extension of the Consultant system employed during the war rather than as an adaptation of the system to hospital staffs depleted of specialists and in need of actual technical support as well as guidance. The duties of Consultants should be extended to actual participation in the treatment of patients and to the assumption of a portion of the work-load of the hospitals in this country. In addition, they should formulate professional policies and participate in, or in many instances actually conduct, the teaching program.

It is realized that this proposal runs counter to the tradition of the Army. It is made, however, in the firm belief that without the assistance of civilians in the present emergency, especially on hospital assignments in the Zone of the Interior, the Medical Department cannot possibly discharge its responsibilities adequately. The extent to which civilians must actually assume a portion of the workload as Attending Physicians and Surgeons will be determined by the rate of recruitment of competent officers for the Medical Corps.

It is important that the terms and conditions under which civilian specialists are employed should be at least as favorable as those the Congress has granted to the Veterans Administration (Appendix IX).

To the extent that the Army secures the services of a representative group of leaders in American medicine, both in a military and a civilian status, it may find that it has broken the bottleneck of procurement. The top professional men, as already indicated, will stimulate the entrance of younger men into the service and will make effective the plans for postgraduate medical training in the Army upon which The Surgeon General properly places such stress. The Committee is of the opinion that if a sufficient number of outstanding professional men can be secured, the Army will be able to put into effect an acceptable system of residencies at certain general hospitals in the Zone of the Interior, with a capacity at any one time for training between 100 and

200 residents in the various specialties. Two warnings, however, are necessary in this connection. The first is that Army residencies must meet the same criteria as are applied to residencies in approved civilian institutions; the mere establishment of the system is not sufficient. The second is that while optimistic opinion suggests that more than the stated number of residents can be trained in the general hospitals, the Committee desires further study of the subject before accepting this conclusion.

The residency program is so important, both as it relates to procurement and as a factor in carrying the work-load, that The Surgeon General should seek expert advice concerning it. It is suggested that a careful analysis be made of the resources of Army hospitals for graduate education in respect to training the general practitioner, the specialist, or both. Each hospital should be scrutinized as to personnel, laboratory equipment, possibilities of liaison with a medical school, facilities for clinical investigation, and, particularly, available clinical material before the details of a curriculum for graduate education can be formulated. Civilian Consultants to The Surgeon General, experienced in graduate medical education, would be able to assist materially in this analysis. In the meantime, the War Department must not oversell the program but must bear in mind that its success will be determined primarily by the available work-load and by the quality of the teaching personnel.

Fifth, it is recommended that certain conditions of service in the Medical Corps be ameliorated.

The explanation of prevailing difficulties in medical procurement can be found in past experience as well as in current conditions. Discontent was widespread among physicians on active Army service during mobilization, the entire war, and the immediate postwar period. Certain complaints are universal. One concerns the enforcement of onerous rules and regulations. Professional men particularly resent the enforcement of regulations which cannot be shown to be necessary, since their entire training has emphasized personal responsibility in an environment of personal freedom.

Another common complaint concerns the disregard of their personal desires and familial responsibilities in the making of assignments. The war reduced to an absolute minimum the amount of consideration that could properly be taken of such matters, but the war is over, and prospective candidates for Regular Army service will certainly be influenced in their final decision to enter or not to enter service by the Army's willingness to consider their personal problems in questions of assignment and reassignment within the limits of departmental efficiency. In this connection it must be emphasized again that there now exists, for physicians who are contemplating a career in the Federal medical service, the option of positions in the Veterans Administration without the dangers

and insecurities of the arbitrary actions unfortunately so typical of Army assignments. This Committee believes that a highly efficient system of personnel management would permit plans and procedures which would substantially reduce instabilities of assignment and location. It recommends immediate institution of remedial action in this respect because it believes that these shortcomings, as well as those exemplified by petty rules and regulations, act as additional obstacles to procurement and could readily be removed.

More important than either of these matters is the universal complaint concerning the inefficient use of professional skills, and, still more basic, the extreme difficulties, under the present Medical Department structure, of learning, or continuing in, any specialty. Of the 136 members of the Society of United States Medical Consultants in World War II who replied to the query whether they would advise a young doctor to apply for the Regular Army Medical Corps, only 18 gave an unqualified "yes"; 14 gave a qualified "yes", and 104 replied "no". The most important change recommended in the Army Medical Department was "assurance that, short of war, the individual doctor might choose a specialty and remain in professional work in that field" (Appendix VI).

In other words, competent and ambitious young physicians will not enter the Army until the Medical Department has accepted a concept of medical service that provides for specialization. Granted that it is desirable for all members of the Medical Corps to have a basic knowledge of the functional activities of the major divisions of the Department, it is not only undesirable but virtually impossible to make each member competent in all fields. The effort to do so by successive shifts in assignment can result only in inefficiency. Once a medical officer has started his training in a specialized field, and has manifested interest and aptitude in it, he should be urged and encouraged to continue in it. The Medical Department must frame both its organization and its policy to encourage functional development along these lines. Once that concept has been fully accepted and adopted, all other measures designed to improve the standards of medical service will follow normally.

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These five recommendations, which concern, first, the pay, rank and conditions of service of the individual medical officer, and, second, the provision of competent professional leadership for him, do not represent a new and untried program. They represent instead

a method of approach which has, in essence, proved strikingly successful in the Veterans Administration. That Administration, starting from an admittedly low professional level fifteen months ago, has made significant and generally recognized progress in medical care, which is acclaimed, in professional medical circles, as remarkable for so short a period. This progress has occurred over the same period in which Army medicine has deteriorated lamentably from its originally very high level.

Analysis of the factors which have made possible this progress by the Veterans Administration shows that the foremost principle has been medical leadership. Just as it is now impossible to attract good young doctors into the Army for a career, so it was formerly impossible for the Veterans Administration to do so, because the medical profession lacked respect for its professional standards. Through the medium of a medical bill, passed in January 1946, medical positions in the Veterans Administration were taken out of Civil Service and the right was given to pay 25 percent increased compensation for Board-certified specialists, making possible top pay in this class of $11,000 for full-time and $6,000 for half-time specialists. With this, and with the elevation of distinguished men from both Army and civilian medicine to posts as professional leaders in the Veterans Administration, assurance was given to physicians generally that they could hold up their heads

professionally if connected with the Administration. Furthermore, the program of locating near medical schools those new Veterans hospitals designated for the care of acutely ill and difficult cases, and of utilizing the faculties of the schools for consultant services on a part-time basis, coupled with the effective establishment of the residency system (which such personnel and such association with the medical schools made possible), gave confidence alike to senior physicians who would head the respective services in the principal hospitals and to the younger men who would serve under them. These factors changed the professional climate of the Veterans Administration hospitals and reversed the attitude of the medical profession toward Veterans Administration medical service.

There is no reason why similar methods adapted to the Army's program, if carried out as vigorously and imaginatively, could not make a similarly successful attack upon existing Army problems. In fact, the Army has very distinct advantages. If the recommendations herein made are accepted and placed in effect, it could offer to the distinguished senior group who would be sought to supply the professional leadership the option either of military careers or of distinguished positions as civilians. A very significant circumstance is that the medical profession does not have the fear that Army medicine would be subjected to the pulling and hauling from local political interests

which has existed throughout in the Veterans Administration and is still definitely a deterrent in the carrying out of its program. The Army has been very largely free from this weakness, a fact which is well known to the medical profession.

Confronted, as the Army now is, with an early prospective inability to give medical care of any reasonable standard of quality, and to be confronted later with the serious risk of not being able to give sufficient medical care of any quality because of the numerical lack of doctors, it is apparent that methods very different from those heretofore employed in the Army will be necessary to meet the crisis. This Committee feels that nothing could be more logical in such a situation than to apply, with proper modifications adapted to the Army's circumstances, the best features of the Veterans Administration plan which experience over the past year has proven to have been conspicuously successful in meeting an even greater problem.

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The Committee concludes this, its first, report with the request that, in view of the urgency of the procurement problem, the recommendations it has made be speedily reviewed and approved. It further recommends that as soon as approval is granted, all staff agencies be specifically instructed to work for their fullest and speediest

implementation. Once these steps have been taken, the widest possible publicity should be given to the Medical Procurement Program of the War Department. The Committee will at this time do all in its power to secure the support of civilian medicine for the program.

At the present time the prospects of meeting even a small part of the Army requirements for medical personnel look exceedingly bleak. The Committee believes, however, that they will be improved if the plan outlined above, which encompasses speedy approval of its specific recommendations, full implementation within the War Department, and widespread publicity, is followed. That the plan will solve the whole problem, however, is gravely doubted, and the Committee would be remiss if it permitted such an optimistic interpretation to stand.

This concludes its first report and the Committee will now direct its attention to a study of other crucial aspects of the problems of the Medical Department.

MEDICAL ADVISORY COMMITTEE TO THE SECRETARY OF WAR

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